HEALTH AND SOCIAL SERVICES

PROJECT DESCRIPTION

OLE2

SUBPROJECT: Health and Social services
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Participating partners:
Norway: Municipality of Bodö
Faroe Islands: The National Pharmacy Service
Sweden: Municipality of Luleå
Observation partner:
Iceland: Municipality of Hornafjördur
Faroe Island: Municipality of Sunda

City of Luleå
Länsstyrelsen Norrbotten
Northern Periphery Programme 2007–2013
EUROPEAN UNION European Regional Development Fund

Enclosures

encl	Document name
A	Health and services activity plan doc
B	Health and services time plan doc

Summary of content

Summary of subproject

The Northern Periphery Area has conceded an implementation from the result from Our Life as Elderly. The municipality of Luleå has certified that the project will be implemented in accordance with national laws and EU regulations. The guidelines for the subproject for Health and Social Services are in contribution to the Northern Periphery programme concepts. The purpose is to establish a system for integrated and coordinated health care between respective providers in the care chain and to establish a system for safe medication. The work with our life as elderly resulted in several challenges for the future. The participating countries Norway and Faroe Islands have similar problems to take care of.

Background

In NP-regions elderly people can feel alienation and difficulties if they don't have access to the health- and social services they need to continue living in their Municipalities. Old people want to be independent and live in there own homes. Preventive efforts directed to elderly can bring great benefits for health and for the economy, both for the individual and for the community. When elderly live longer at home it is a great matter to prevent errors of wrong medication handling. Supporting independence of elderly should also go hand-in-hand with a system of safe medication so they don't take too much or to little and at the right time. Hospital visits can be avoided if the medication is right; today many hospital visits are caused by wrong medication. The responsibility for health promoting and preventive work lays on the Municipality and the County Council. It is important that the communication and the cooperation between the levels in the care chain work and are safe so the elderly get the right help.

Our Life as Elderly was a trans national project and focused on future elderly care. The project showed that there is a fairly high level of variation in the health service structure in the participating countries but the differences are mainly related to responsibility, organisation, accessibility, capacity, and level of skills and expertise.

The subprojects suggestions for the future are about:

- To work for preventive care on all levels.
- To have a constructive toolkit for preventive health care.

- To develop a common attitude and value during all levels in the care chain.
- To work for positive interaction – cooperation. Develop a good climate between the various levels of the health services.
- To concentrate effort on attitudes to, and knowledge of illness and ailments that particularly affect the elderly.
- To take new technology in use – work on attitudes and knowledge – information
- Aim at ensuring sufficient capacity, access to, and scope of services – this preconditions inclusion in the Municipality long term plans.
- Face the challenges posed by providing care for dementia suffers.

Current situation in Sweden

Home visits

The municipality in Luleå have 73 448 inhabitants. In Luleå the district nurse at the health centre in the County Council makes organized home visits among elderly over 80 years. The Swedish government gives subsidies as incentive measures to the health centre for the preventive home visits. It is an ongoing project and it will last until till the end of 2009. They get informed about their medication, nutritional status and make risk assessment about fall risk. In one of the County councils districts the district nurse cooperate with the staff from the municipality about the visits.

The municipality of Luleå is also getting subsidies as incentive measures from the government for making home visits among elderly over 80 years in preventive purpose. The project in the municipality will last until the end of 2009. The visits are preventive and they get information about how they can get help in different areas There is cooperation whit the district nurse in one of the County councils district but in the other two districts there is no cooperation. The experiences are good when the visits are made together with both responsible parts because they get an overall picture about the situation. The major parts of the elderly are very satisfied and happy about the visits.

In purpose to examine if some other organisation makes home visits contact was taken with one of the congregations in Luleå. In Luleå the church congregations have no organized home visits among elderly but the state church invites all elderly over 80 years by a letter to a common lunch once a year. They get informed of how they can get in contact with the church even

if they don't want to participate at the lunch. In grief they have a routine to contact the surviving relative and offer conversation or home visit.

Medication
In the municipality of Luleå elderly at home in need of help with medication gets it from the staff/assistant nurses from the home-help service with delegation for medical treatment. They can get their medication dosed and packed for 14 days at time from the chemistry, called "Apo-dos", or the district nurse from the County Council administer the medication in a "dosett" regularly. When the medication from the home care staff is given they sign the given dose on a document/sign list.

In some districts in Sweden the County Council have tested an electronic medicine "dosett" whit good experiences. They have bought the "dosett", called "Careosel", and the district nurse can borrow it to those who may have advantage of it and can manage it by themselves. The electronic "dosett" is suitable for people suffering from dementia in early phase. The district nurse administers the medication regularly depending on how often the dose has to be taken. There is also an ongoing project in the neighbour municipality where the County Council is involved. The idea is that the telephone gives a signal when its time to take the medicine dose, this system direct to people not suffering from dementia. The field test will start in august 2009.

Information system
The County Council and the municipality cooperate in an information transfer system called "Meddix" when people are hospitalised. The purpose of the system is to secure the levels in the care chain and if needed make a care plan together before the patients are discharged from the hospital.

Current situation in Norway

Home visits
In the municipality of Bodö in Norway with 46 049 inhabitants the care of elderly has focus on preventive health care. Today the practised home visits are based on a random sample with different age groups in elderly years. The visits are based on elderly needs and demands; there is no routine for risk assessment. They get informed about what activities the municipality

can offer to prevent loneliness and information about other preventive issues as physical activity, diet etc. From 2009 they are planning to visit all elderly over 80 years. A nurse with special education in preventive health care or psychiatric health care makes the visits. The County Council have no role in the visits; all responsibility is in the municipality.

Medication
It is the municipality's responsibility to help elderly at home with medication. It is the home care nurse who administers the medication in a "dosett" and the staffs from home care nurse or assistant nurse with delegation for medical treatment that gives them the medication. When the medication is delivered and given its signed on a document. They are now working with a new project called "Multidose" in the home care. It's a special project were each medical dose is paced closed and finished from the chemistry, this project will be involved in OLE 2.

Information system
They are working with different models for cooperation between the levels in the care chain. This work is going to have a strong focus in the project.

Current situation in Faroe Island

Home visits
In the Faroe Islands with 48 433 inhabitants the municipalities have no system for organized home visits. The home government does not have any organized home visits but two of the larger municipalities have on their own initiative started home visits. All citizens over 75 years are offered visits two times a year. The purposes for the visits are to look at safety in the home, information about available services, financial and other support to prevent any kind of problems. The home visits are made by staff with health oriented education like nurses.

Medication
In the Faroe Island the nurse administers the medication in a dosett mostly every second week if the situation is stable. It is the staffs from the home help care service that gives the medication if they cant take it themselves. Only a nurse or a health worker is qualified to do medicine doses, home workers are only allowed to give medicine from package doses. The staff is not required to sign the given medicine doses except for morphine. There is no other

system about medication in residents own home but some nursing homes are piloting in a system about medicine "dosetts".

Current situation in Iceland

Home visits

In Iceland the municipality in Hornafjördur with 2120 inhabitants have a contract whit the County Council about home visits. Previously elderly over 75 years were offered a visit from a home care nurse but for the last 2-3 years there has been no visits because there is a lack of nurses. At the time there is no organized home visits for elderly over 80 years neither from the municipality or the County Council.
The Red Cross is an organization that makes visits for elderly over 80 years at home.

Medication

In Iceland the medication is administered in a pharmacy in Reykjavik and sent by mail every 2 weeks to the elderly residents, or to the health care centre and home nurses brings it to the elderly. The tablets are prescribed and put into small bags whit the patients name, date and instruction as to when to administer the tablets. When help is needed with the medication the elderly gets it from a nurse or nurse assistant. The medication is not documented on a sign lists.

Objective

The main objective of this subproject is to establish an integrated and coordinated system between the providers in the care chain and to establish a system for safe medication. Areas for priority are for instance to; develop and introduce a planning tool; create and or select communication system; create and or select coordination, health-planning tool, IT-based; necessary organizational changes and new models implemented.
Our objectives can be dividing in 3 groups:

- To establish into day-to-day operations a number of changes, through new services and products, fully integrated in our regions organizations.
- To package these in a manner so that they can be distributed, multiplied, taught and used in other municipalities.

- To stimulate other regions to follow our joint initiative.

Expected results

- A system for cooperation between the municipality and the county council for systematically seeking elderly people in their own homes. In the Faroe Islands elderly over 75 years, in Luleå/Sweden and Bodö/Norway elderly over 80 years.
- A tool for risk assessment so old people can live in their own homes as long as they like by identifying there needs and eliminate risks in their environment.
- A developed information system between the levels in the care chain.
- Developed systems for secure medication for elderly at home, maybe with new technology.

Limitations

The projects direction is to work trans national with the findings from Our Life as Elderly part 1. It is necessary to cooperate with other organisations to develop a system for taking care of the elderly in all levels in the future. The time frame for the project is from 2008-10-15 until 2011-05-31 and the direction is preventive care of elderly at home.

Project organization

- Project owner: Management Group
- Steering group: Transnational steering group
- Transnational project manager; Lena Perttu, Luleå Sweden. The main project group in Sweden is compound by Anne-Marie Jansson, unit manager of geriatric care from the municipality of Luleå, Ann-Kristin Lehmivaara district nurse from the County Council, Susanne Füreder assistant nurse from the Flora home care service in Luleå and other skills when needed.
- National project manager; Åse Bente Mikkelborg, Bodö Norway. The main project group in Norway is compound of Mona Olsen occupational therapist, Irene S Haugen prevent nurse, Ann Cathrin Krane Lyng nurse and a doctor as a reference.

- National project manager; Olov Briem, Faroe Island. The main project group in Faroe Island is compound by Asa Hanusson nurse/district manager and staff from Naerverk.

This trans national project group will be acting under the trans national management group. Observation partner in the project is the municipality of Hornafjördur on Iceland. The Municipality of Sunda in Faroe Island is participating as observer regarding home visits.

Time frames

The total time frame is from2009 03 to around 2011 05 31. In addition see under Time plan.

Resources

Study visits and litterateur supply may be necessary in the project work. Meeting with the project group and future workshops. The budget for the OLE 2 project is coordinated for all included subprojects.

Project plan

Methods

The national project managers are responsible for the work in their region. This work will be done differently in each country but the Swedish transnational project manager has the main responsibility to coordinate the work. The work will proceed in work packages. The participating countries are all responsible for each work package to set up what should be achieved during the period. The Faroe Island is responsible for WP 2. Bodö, Norway is responsible for WP 3 and Luleå, Sweden is responsible for WP 1 and WP 4.

Work package 1 – Management, co-ordination and communication 2008 06 01 – 2011 05 31

- General kick off for all participants 2008 10 13-14

Work package 2 – Description of implementation 2008 10 – 2009 02

- Describe content of intended implementation
- Describe organizational frame
- Describe how the cooperation with concerned parts will work
- Describe area of responsibilities

Work package 3 A–Define change 2009 03 – 2010 02

- Define what changes must be done to operate new approach
- Define what methods are needed to fulfil requirements
- Define what required technical support is needed to sustain change
- Propose time and action plan for implementation

Work package 3B – Working with implementation 2010 03 – 2011 05

- Create acceptance for the proposed change
- Time and action plan to be confirmed and accepted
- Introduce changes and implement products where applicable in all aspect
- Allow for adjustment in content and time so that the introduction of the change will be coordinated with responsible partners
- Follow up results in operations
- Secure stability in change
- Dismantle project groups
- Formal handover of implemented changes into day to day operations/organizations
- Document process, procedures and results

Work package 4 – Dissemination and external communication, from project start – 2011 05

Information plan.

Activities planned for the periods below will/period will/include the following main areas:

- Public meetings and hearings
- Web activities
- Media exposure

- National Conference on project, completion, results and process. In each participating country
- One Transnational Conference on our completion
- Participation in minimum at one national conference per country participating to present OLE 2, content, objectives all products and results

Project process

The work will go on in three steps and is based on the conclusions from OLE

- Determine content, areas of responsibility and function
- Select and describe methods where applicable for planned and proposed activities
- Decide on an organizational integration in close cooperation with concerned organizations
- Follow through into actual full start

Activities

See document A; Health and Social Services Activity plan

Time plan

See document B; Health and Social Services Time plan

Information activities

- Trans National activities and national successes in the project will be focus for press releases.
- Politicians, stakeholders, staff and management will be informed at different types of meetings.
- Our primary information activity will be at homepages, national and project pages.
- The projects homepage www.ourfuture.eu will be a gateway for project papers and activities as well as a platform for project workers.

Risk analyze

- Low interest for the project from the County Council and the municipality
- Members in the project organization, project group quits
- Cooperation problems in the project group
- The time frame is to short
- The results can not be transferred in the organization
- The budget for the project is not sufficient

References

Final report Health Services,
(http://www.ourfuture.eu/step-1/project-health-services.htm)
Health_Care_final Report.pdf
Application OLE 2 - Our Life as Elderly Implementation